STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. BUILDING _____ B. WING _____	C 03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB AND HC CTR AT VILLAGE GR	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, Responsible Party (RP) interview and staff interviews, The facility failed to honor confidentiality and privacy by transferring medical records to another facility for 1 of 1 sampled resident.(Resident # 3)	F 164	F 164: 483.10(e), 483.75(l) (4) □ PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 1) Actions taken for Residents #3: A. With regards to resident #3, no	4/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/28/2017

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F 164	Continued From page 1 Findings included: Resident # 3 was admitted to the facility on 9/29/2015 with diagnosis of Hemiplegia, Cerebrovascular, Muscle weakness, Dysphagia, Hypertension. The Minimum Data Set (MDS) dated 1/13/2017 indicated the resident was severely cognitively impaired. During the interview with the director of Social Services on 3/13/2017 at 10:55 AM. She reported the RP did not speak with her personally regarding the transfer of the medical records to another facility. She further reported the RP spoke to Nurse # 1 about looking into transferring the resident to another facility. During the interview with Nurse # 1 on 3/13/2017 at 11:30 AM, she reported she did not document anywhere in the records regarding the RP giving consent to transfer the medical records to another facility. During the interview with the RP on 3/13/2017 at 11:45 AM, he reported he did not give any consent to the facility's staff to transfer medical records to another facility. During the interview with Administrator on 3/13/2017 at 3:00 PM, he reported he expected the staff to have document the conversation with the RP regarding consent to transfer the medical records to another facility.	F 164	corrective action could be taken since the resident information had already been disseminated. We did apologize to resident #3 and the RP for the error. 2) Actions taken for all residents due to the potential for being affected: A. On 3/28/2017 the appropriate facility staff were in-serviced by the Social Worker regarding: (1) The importance of documenting that a resident or RP has requested for resident information to be sent outside the facility prior to the dissemination of the information. 3) Actions taken to prevent further recurrence: A. Social Worker, or designee, will audit all requests for information to be sent out of the facility 2X week for 4 weeks for proper documentation of such request. B. Following Step 3A, Social Worker, designee, will conduct random monthly audits X 2 months, followed by quarterly X 2 quarters, and as needed for compliance with documentation of all requests for resident information. 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. Social Worker, designee, will bring results of audits to morning administrative team meeting for review, weekly X 4 weeks. B. Results of all audits will be brought to the facility QAA meeting by the Social Worker, designee, and reviewed by the QAA committee monthly X 2 months, quarterly X 2 quarters, and as needed. C. Any non-compliance with established	

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F 164	Continued From page 2	F 164	plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-in servicing of the applicable staff by the Social Worker, or appropriate designee. F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, Responsible Party (RP) interview and staff interviews, The facility failed to acquire consent before transferring medical records to another facility for 1 of 1 sampled resident.(Resident # 3) Findings included: Resident # 3 was admitted to the facility on 9/29/2015 with diagnosis of Hemiplegia, Cerebrovascular, Muscle weakness, Dysphagia,	F 250	F 250: 483.15(g) (1), □ PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 1) Actions taken for Residents #3: A. With regards to resident #3, no corrective action could be taken since the resident information had already been disseminated. We did apologize to resident #3 and the RP for the error. 2) Actions taken for all residents due to the potential for being affected:	4/10/17

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F 250	Continued From page 3 Hypertension. The Minimum Data Set (MDS) dated 1/13/2017 indicated the resident was severely cognitively impaired. During the interview with the director of Social Services on 3/13/2017 at 10:55 AM. She reported the RP did not speak with her personally regarding the transfer of the medical records to another facility. She further reported the RP spoke to Nurse # 1 about looking into transferring the resident to another facility. During the interview with Nurse # 1 on 3/13/2017 at 11:30 AM, she reported she did not document anywhere in the records regarding the RP giving consent to transfer the medical records to another facility. During the interview with the RP on 3/13/2017 at 11:45 AM, he reported he did not give any consent to the facility's staff to transfer medical records to another facility. During the interview with Administrator on 3/13/2017 at 3:00 PM, he reported he expected the staff to have document the conversation with the RP regarding consent to transfer the medical records to another facility.	F 250	A. On 3/28/2017 the appropriate facility staff were in-serviced by the Social Worker regarding: (1) The importance of documenting that a resident or RP has requested for resident information to be sent outside the facility prior to the dissemination of the information. 3) Actions taken to prevent further recurrence: A. Social Worker, or designee, will audit all requests for information to be sent out of the facility 2X week for 4 weeks for proper documentation of such request. B. Following Step 3A, Social Worker, designee, will conduct random monthly audits X 2 months, followed by quarterly X 2 quarters, and as needed for compliance with documentation of all requests for resident information. 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. Social Worker, designee, will bring results of audits to morning administrative team meeting for review, weekly X 4 weeks. B. Results of all audits will be brought to the facility QAA meeting by the Social Worker, designee, and reviewed by the QAA committee monthly X 2 months, quarterly X 2 quarters, and as needed. C. Any non-compliance with established plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be	

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F 250	Continued From page 4	F 250	included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-in servicing of the applicable staff by the Social Worker, or appropriate designee. F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		4/10/17

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F 278	Continued From page 5 material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately assess the functional limitation in range of motion for the quarterly minimum Data Set (MDS) assessment and the Annual Comprehensive Assessment for one (1) of five (5) sampled residents. (Resident #1) The findings are: Resident # 1 was admitted to the facility with diagnosis of Hypertension, Peripheral Vascular Disease, Diabetes Mellitus, and Dementia. A review of the resident's medical record revealed staff had assessed the resident's as no upper extremity impairment in the Quarter MDS assessment dated 1/26/17 and the Comprehensive Annual MDS Assessment dated 05/03/2016. During an interview on 3/13/17 at 3:12 PM, the MDS coordinator acknowledged the assessment must have been missed or was overlooked, because Resident (#1) has upper extremity impairment. During an interview on 3/13/17 at 3:25 PM, the Administrator and the Director of Nursing (DON) indicated their expectations of MDS Staff was to complete the MDS accurately.	F 278	F 278: 483.20(g) □ (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 1) Actions taken for Residents #1: A. With regards to resident #1, the MDS was immediately corrected to accurately reflect that the resident has upper extremity impairment. 2) Actions taken for all residents due to the potential for being affected: A. On/before 4/10/2017, the MDS Coordinator, appropriate designee, will visually assess all residents for upper or lower extremity impairment. The MDS Coordinator, appropriate designee, will then compare all assessments to the MDS to ensure accurate coding. B. On 3/28/2017 all MDS nursing staff were in-serviced by the ADON regarding: (1) The importance of capturing extremity impairment coding properly for MDS/Care Planning. 3) Actions taken to prevent further recurrence: A. MDS Coordinator, or designee, will audit all Initial MDS Assessment Sheets 2X week for 4 weeks for proper extremity impairment coding. B. Following Step 3A, MDS Coordinator, designee, will conduct random monthly audits X 2 months, followed by quarterly X 2 quarters, and as needed for compliance with extremity impairment coding in the MDS Any non-compliance will be	

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F 278	Continued From page 6	F 278	addressed by the MDS Coordinator, designee, as soon as practical. 4) Monitoring for outcomes of established plan and involvement of facility QAA/QAPI committee: A. MDS Coordinator, designee, will bring results of audits to morning administrative team meeting for review, weekly X 4 weeks. B. Results of all audits will be brought to the facility QAA meeting by the MDS Coordinator, designee, and reviewed by the QAA committee monthly X 2 months, quarterly X 2 quarters, and as needed. C. Any non-compliance with established plan will reviewed by the QAA/QAPI committee for root cause and interventions implemented as needed and/or established plan revised. D. Discussion, interventions, and/or revisions to established plan will be included in the meeting minutes. E. Any adjustment to the established plan, through revision and/or interventions for non-compliance will require re-in servicing of the applicable staff by the ADON, or appropriate designee. F. Any revision to the established plan will require the monitoring to begin again at Step 4A and continue as outlined.	